PRINTED: 03/14/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER SIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
£		. 445310	awin	G	03/	09/2011
1980	PROVIDER OR SUPPLIER RE CENTER OF COPP	PER BASIN		STREET ADDRESS, CITY, STATE, ZIP COU 166 COPPER BASIN INDUSTRIAL PA DUCKTOWN, TN 37326		18 .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FL :). BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ACTION OF TH	SHOULD BE	COMPLETION DATE
\$\$=D	During annual recent complaint investigate March 7 - 9, 2011, at Basin, no deficiencies complaint under 42 (Requirements for Louis 483.10(b)(11) NOTIF (INJURY/DECLINE/INJU	tification survey and on #25714, conducted on the Life Care Center of Copples were cited in relation to the CFR PART 482.13, and Term care. TY OF CHANGES ROOM, ETC) diately inform the resident; lent's physician; and if ident's legal representative by member when there is an eresident which results in tential for requiring physicial cant change in the resident sychosocial status (i.e. and, mental, or psychosocial eatening conditions on the properties of the discontinue and the discontinue and the discontinue and the transfer or discharge commence a new form of the transfer or discharge to the commence and the commence of the comm	he F 15	I'M GU CO	deficiencies on of Life Care to comply inue to c. OF ME/ROOM, See so found to ent practice? g for resident that if meds cumented on of MD	4/12/2011
a c c c c c r n tt	and, if known, the resion interested family mechange in room or roospecified in §483.15(eesident rights under Fegulations as specifients section. The facility must recorded address and phone in the recorded address and phone in the facility must recorded and the facility must record	promptly notify the resident dent's legal representative ember when there is a mmate assignment as e)(2); or a change in ederal or State law or d in paragraph (b)(1) of and periodically update number of the resident's supplier representatives supplier.		What corrective actions will be to All residents have a potential to be All current residents have been and ensure circled medications have redocumented and MD notification. conducted by DON, ADON, Unit I SDC and were completed on Marc What measures will be put into paystematic changes will be made that the deficient practice does not the action of the systematic changes will be made that the deficient practice does not be actioned to be	e affected. dited to asons Audits Managers, h 24th 2011.	

ram participation.

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that it safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 of following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIED CLIA IDENTIFICATION NUMBER:	(X2) MUI.	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		445310	B. WING			03/09/2011
	PROVIDER OR SUPPLIER ARE CENTER OF COPF	ER BASIN		REET ADDRESS, CITY, STATE 166 COPPER BASIN INDUS DUCKTOWN, TN 37326		3OX 518
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I 18.L C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD B TO THE APPROPRI	
	Iegal representative This REQUIREMEN' by: Based on medical repolicy for Medication interview, the facility of running out of ABH resident (#7) of twentous The findings included Resident #7 was adminated and readminated January 24, 200 had short and long tertotally dependent with assistance for bed meand bathing. Further indicated pain by nonexpressions and prote Further review revealed.	or interested family number T is not met as evidenced cord review, review of the Administration, and failed to notify the physician IRP (Ativan) cream for one cy-four residents reviewed. It interested family numbers with Muscle Weakness, and Right Humeral Head Tof the Minimum Data Set 11, revealed the resident memory problems; was two plus person physical ibility, transfer, toilet are review revealed the resident		Nursing staff were re-ed documentation on back of circled medication and donotification. Re-educated staff development coord ADON, and was comple 2011. How the corrective actimonitored to ensure the will not reoccur? What program will be put into the DON, ADON, and the audit daily to ensure that circled there is reason do MAR and there is documentification. The findings taken to the Performance Committee by the ADON months. The next meeting	of MAR reason follocumentation of locumentation of on was done by the inator, DON, or sted by March 24 loon(s) will be deficient practic quality assurant oplace. Unit Managers with a medication in commented on backentation of MD is of the audits will improvement.	th, tice tce ill is ck of
t t	Medical record review order dated October 1 ABHRP (Ativan) cre opically q (every) 6 ho	am apply 1 ml (millillier) urswhen cream an wes n 1 mg (milligram) pc (by			ti ti	
i iv	redical lecold texiew (or the buysician briono			107	

PRINTED: 03/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/(!) \ AND PLAN OF CORRECTION IDENTIFICATION NUMBI A. BUILDING B. WING 445310 03/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK PO BOX 518 LIFE CARE CENTER OF COPPER BASIN DUCKTOWN, TN 37326 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUI PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATIC: CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 157 Continued From page 2 F 157 order dated February 4, 2011, revealed "..." (change) ABHRP cream to 3 x (times) daily 2) Ativan 2 mg po g day until ABHRP cream available...' Medical record review of the February 2011 Medication Administration Record (MAR) for ABHRP cream revealed on February 7, 201 | the ABHRP cream was not administered at 9:00 p.m.: on February 8, 2011, the ABHRP cream was not administered three times; and on February !! 2011, at 3:00 a.m. the ABHRP cream was not administered as indicated by the circled initions. Further review of the back of the MAR revealed no documentation to explain why the ABHRI was not administered. Review of the facility policy for Medication Administration revealed "...Procedure...14. Circle initials on MAR if medication is not administered as ordered and record reason on MAR...21. 'I medication is ordered but not present; a. Check other resident drawers to see if it was placed in the wrong drawer...b. Call the pharmacy or supervisor to obtain the medication..." Interview, with the Regional Nurse in the dining room, on March 9, 2011, at 9:00 a.m., confirmed the ABHRP medication was not administered on February 7, 8 and 9, 2011, and confirmed there was no documentation the physician had bee notified.

practice is safe.

483.10(n) RESIDENT SELF-ADMINISTER

the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this

An individual resident may self-administer druns if

DRUGS IF DEEMED SAFE

F 176

SS=D

SAFE

SS=D

F 176 483.10 (n) RESIDENT SELF-

What corrective action(s) will be

ADMINISTER DRUGS IF DEEMED

4/12/201.1

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DEPARTMENT OF HEALTH AND HUMAN SERVE ES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER ILA IDENTIFICATION NUMI IR	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION '	(X3) DATE SURVEY COMPLETED	
		445310	B. WING_	7	03/0	9/2011
	PROVIDER OR SUPPLIER ARE CENTER OF CO			REET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PAR DUCKTOWN, TN 37326		
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F 176	Continued From p	age 3	F 176	accomplished for those resident have been affected by the defici		
*	by: Based on medical policy, observation to assess a reside	iNT is not met as evidenced record review, review of facility and interview, the facility failed at for self-administration of e (#12) of twenty-four residents		Resident #12 was assessed for sel administration of medication per passes not deemed safe for self administration. Resident was informational bring medication to resident scheduled and prn.	policy and inistering ed that nurse	
	admitted to the fact diagnoses to include Review of the Minir January 4, 2011, re "15" on the Brief Int (BIMS) indicating the	ew revealed resident #1. was lity on January 22, 2007 with e Chronic Airway Obstruction. num Data Set (MDS) dated vealed the resident scored erview for Mental Status e highest score possible for orientation, and recall.		Residents identified as having the to be affected by the same deficit. What corrective actions will be a All residents have a potential to be Residents currently self administer medication have been identified an according to self administration potential monitoring of residents was done to Manager, DON, or ADON and was by March 24th 2011.	ent practice. taken? affected. ring ad assessed blicy. The by the Unit	
	dated November 13	ew of the Telephone Orders , 2010, revealed an order to lizer treatments three times a		What measures will be put into p systematic changes will be made that the deficient practice does no	to ensure	
	dated January 23, 2	ew of the Telephone Orders 011, revealed an order to ulizer treatments "PRN" (as		Nursing staff were re-educated on a for self administration of medication education was done by the staff decoordinator, DON, or ADON and we completed by March 24th 2011.	ons. The velopment	
r i	Each resident who nedications is perm ntérdisciplinary tean	of Medications" revealed desires to self-administration itted to do so if the facilities had determined the practice e resident and other residents		How the corrective action(s) will monitored to ensure the deficient will not reoccur? What quality as program will be put into place?	practice	

		IDENTIFICATION NUM R	A. BUILE	DING	(X3) DATE SURVEY COMPLETED		
	*	445310	B. WING		03/0	9/2011	
	F PROVIDER OR SUPPLIER CARE CENTER OF COPF	PER BASIN	s	STREET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARI DUCKTOWN, TN 37326		(PO BOX 518	
(X4) IE PREFI TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FIRE C IDENTIFYING INFORMATION()	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 17	revealed resident #1 bed receiving supple cannula. Continued hand-held nebulizer estimated ¼ solution chamber. Continued with resident #12 revonly give me 4 treatr to make them last loafter they give me or sometimesJust tak Continued observation resident had an amp Albuterol in the bedsitt." Observation reve	ch 7, 2011, at 11:10 a.m., 2 sitting on the side of the ement oxygen via nast on the bedside table with an aremaining in the medication dispersation and interview realed, "They (the number) nents a day! split them up need one sight ne! get really short-winded ing a little helps a lot" on and interview revealed the ule of the medication de table to use "when I need aled resident #12 turned on administered a nebularition		Residents will be monitored week that the self administration policy followed. The audits will be conditioned. ADON and Unit Managers, findings of the audits will be taken Performance Improvement Commandon for the next three months. Immeeting is set for April 12 th .	is being ucted by the The to the ittee by the		
		eview' dated March 7, 2011, idicated, "This resident does petency in					
F 280 SS=D	verified the resident w administer medication the resident to self-ad- treatments. 483.20(d)(3), 483.10(k	7, 2011, at 2:20 p.m as not safe to self s and the facility allowed ministration the nebulitor c)(2) RIGHT TO NING CARE-REVISE (1) ight, unless adjudged ise found to be		F 280 483.20 (d) (3) 483.10 (k) (2) I TO PARTICIPATE PLANNING (REVISE CP SS=D		4/12/2011	

		(X1) PROVIDER/SUPPLII : CLIA IDENTIFICATION NUT HER:	(X2) MULT	FIPLE CONSTRUCTION .	(X3) DATE (COMPL	
		445310	B. WING	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	03/0	09/2011
	PROVIDER OR SUPPLIER RE CENTER OF COPP	PER BASIN	1.1	REET ADDRESS, CITY, STATE, ZIP CO 166 COPPER BASIN INDUSTRIAL I DUCKTOWN, TN 37326	DOE	
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F 1 1 E M h ti	participate in planning changes in care and A comprehensive cas within 7 days after the comprehensive assess interdisciplinary team physician, a registere for the resident, and disciplines as determined, to the extent protection of the extent pro	re plan must be developed the completion of the exament; prepared by an another exament; prepared by another appropriate staff in a sined by the resident and educable, the participation of dent's family or the resident's and periodically reviewed an of qualified persons after date two resident's (#14, ety devices to prevent falls directly and Osteoporosis. The resident sustained falls dates and the following the put in place: June to prevent sliding) to		What corrective action(s) will accomplished for those reside have been affected by the def Resident # 14 care plan was up current interventions in place for Resident # 7 care plan was upd current interventions in place for Residents identified as having to be affected by the same def What corrective actions will be All residents having safety devidence a potential to be affected, with safety devices were audited care plan matches current interventioned. The audits were done be ADON, SDC, Unit Managers. Accompleted by March 24th 2011. What measures will be put interventionally with the deficient practice does that the deficient practice does that the deficient was given by the DON, or ADON and was completed to ensure the deficient vill not reoccur? The Unit Managers, DON, ADON harts for careplan updates on an or safety devices. New orders with respective devices.	ents found to icient practice? dated to match or resident, ated to match or resident. the potential icient practice, the taken. ces in place All residents in to ensure that centions by the DON, audits were not reoccur. on place or le to ensure in the reoccur. on updating to ordered, the SDC, ched March ill be int practice. N will audit y new orders	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUM R:		(2) MULT	TIPLE CONSTRUCTION .	(X3) DATE S COMPLE	URVEY ETED
	\$8	445310		WING_		03/0	9/2011
	PROVIDER OR SUPPLIER RE CENTER OF COPF	PER BASIN		1	REET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK DUCKTOWN, TN 37326		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)		ID REFIX FAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	against the wall with 2, 2010, pressure al chair.	ge 6 mat at bedside, and Augus arms to be applied to had a	st and	F 280	daily. The findings of the audits wito the Performance Improvement Coby the ADON for the next 3 months beginning with the next meeting what for April 12 th , 2011.	ommittee /	
	revealed no interven the wall, or pressure Interview with the Un Coordinator's office of	tions of dycem, bed against alarm. It Coordinator in the Unit on March 8, 2010, at 10 30 resident's Care Plan had riched.	st			,	[80]
	23, 2010, and readmi diagnoses including N	nitted to the facility on Marc itted on June 4, 2010, with Muscle Weakness, and Right Humeral Hend	ch				
t t e iii e F	dated January 24, 20, and short and long ter otally dependent with assistance for bed most and bathing. Further andicated pain by non-expressions and protes further review reveals observed one to two diene review process. Further review process. Further review process.	of the Minimum Data Set 11, revealed the resident memory problems; was two plus person physical obility, transfer, tollet use review revealed the resident verbal sounds, facial active body movements, and pain or possible pain was ays of the last five days in or the last five days in or a fall after admission with	nt s				
N A	fedical record review ssessments dated Ju	of the Fail Risk ly 3, 2010 through January resident was at high resk	/	,		3	

6 4234961906

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/SULA IDENTIFICATION NUMBERS	9	ULTIPLE CONSTRUCTION LDING	N	(X3) DATE SURVEY COMPLETED:	
		445310	B. WIN	(G	<u> </u>	03/0	09/2011
	PROVIDER OR SUPPLIER ARE CENTER OF COPP	PER BASIN		STREET ADDRESS, CITY 166 COPPER BASIN DUCKTOWN, TN	I INDUSTRIAL PAR	K PO BOX 51	8
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU. SC IDENTIFYING INFORMATION	PREFII TAG	X (EACH CORF	R'S PLAN OF CORRE RECTIVE ACTION SHO RENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 280	for falls. Medical record reviet dated August 2, 201 while in bed-check of functioning and place safety" Medical record reviet dated August 10, 20 sides of bed" Medical record reviet August 12, 2010, reviet August 12, 2010, reviet August 12, 2010, reviet B/11/10. Res (Resid of bed) to bed side medical record reviet August 12, 2010,	ge 7 ew of a physician phone order 0, revealed "Pull tab plarm (every) shift for proper ementmat beside bed for w of a physician phone order 10, revealed "Mats to both w of the nursing note doted realed "Late entry for ent) noted to climb OON (out nat. Small abrasion are prearmno other injuries	F 2	80			
	October 17, 2010, revenues witnessed to start of bed and fall sideware head hitting head on Aide) was in room wit witnessed and was ur						
	October 23, 2010, rev with head off (mat)h eyebrow. Neuros per called, MD notified and	protocol. Res spouse	s				
		mentation dated August 11, 0; October 23, 2010; and					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIEF (CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	
	<i>E</i>	445310	B. WING		03/0	9/2011
	PROVIDER OR SUPPLIER ARE CENTER OF COP	PER BASIN	s	TREET ADDRESS, CITY, STATE, ZIP CO 166 COPPER BASIN INDUSTRIAL F DUCKTOWN, TN 37326	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMAT (IN)	PREFIX TAG	PROVIDER'S PLAN OF CO. (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
1	January 10, 2011, in fallen out of the bed documentation the bed documentation the bed Further review of the August 11, 2010, resintervention was to pwith a pull tab alarm documentation dated the additional intervention mental check placement. Further documentation dated the additional intervention mat on wall, bed turn placing 3 mats vertice the facility document 2011, revealed the alarm to bed side to a gainst the wall. Review of the care placed mat and got a deed and the resident straps, in constant morail and got a skin tear revealed the resident room and four mats with bed was against the wall and the bed; the wall and the bed; the resident the wall and the bed; the resident the wall and the bed; the wall and the bed; the resident the wall and the bed; the resident the wall and the bed; the wall and the bed; the resident the resident the wall and the bed; the resident the resident the wall and the bed; the resident the resident the wall and the bed; the resident the resident the wall and the bed; the resident th	revealed the resident had and there was no bed alarm was sounding, a facility documentation dated vealed the additional place the resident in a recliner. Further review of the facility of October 17, 2010, revealed entions were to do a falarms and furniture review of the facility of October 23, 2010, revealed ention was low bed in place, and to wall, rearrange mats ally to bed. Further review of action dated January 10 additional intervention was to able was across the room and dated April 8, 2010, and the free the order was obtained continued review revealed added on October 23, 2010. In 7, 2011, at 1:52 p.m., in a Broda chair with thigh often, hit her left forehand on the continued observation was taken to the resident's the wall with a mat between the bed was in a low.	F 280			DOMAN AND
	Interview with the Unit	Coordinator in the Unit March 8, 2010, at 12:20				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ UA IDENTIFICATION NUMB 1::	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ,	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER ARE CENTER OF COPF	PER BASIN		REET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK DUCKTOWN, TN 37326	PO BOX 518
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F 280	, , ,	TO	F 280		
F 281 SS=D	been updated to refl 483.20(k)(3)(i) SERV PROFESSIONAL STATES	resident's Care Plan had not ect the interventions. VICES PROVIDED MET T TANDARDS ed or arranged by the facility and standards of quality.	F 281	F 281 483.20 (k) (3) (i) SERVICES PROVIDED MEET PROFEESSIC STANDARDS SS=D	
	by: Based on medical re the facility failed to di	T is not met as evidenced cord review and interview, iscontinue a medication as cian for one resident (#/+) of		What corrective action(s) will be accomplished for those residents fo have been affected by the deficient Resident # 1 MD was notified and Arwas D/C'd on March 8th 2011.	practice?
	March 4, 2011, with a Tract Infection, Dyspl Dementia, and Alzhei Medical record review Reconciliation form fr 4, 2011, revealed the the hospital on Februa continue Amlodipine (admitted to the facility on diagnoses including Urinary hagia, Decubitus Ulcer imer's. If of the Medication on the hospital dated March resident was admitted to any 27, 2011, with orders to blood pressure medication years the medication was		Residents identified as having the p to be affected by the same deficient What corrective actions will be take All residents being admitted or re-admitted facility have a potential to be affect The DON, ADON, Unit Managers or audited all residents being admitted affest Medication Recapulation complet February 28 th 2011 to ensure that all medication reconciliation forms (home form) were completed upon admission facility. Audits were completed March	practice, en? mitted to octed. SDC of the the ed e med on to the
	Admission Orders dat no orders for Amlodip Medical record review Administration Record	of the MAR (Medication) dated March, 2011, ing had been administered		What measures will be put into plac systematic changes will be made to e that the deficient practice does not r Nursing staff were re-educated on follo policy for medication reconciliation (h	ensure eoccur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIES ALIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445310	B. WING		03/0	9/2011
	PROVIDER OR SUPPLIER ARE CENTER OF COF	PER BASIN		REET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK DUCKTOWN, TN 37326	*	¥
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F 315	(licensed practical 10:10 a.m., at the r resident had receiv without a physician 483.25(d) NO CAT RESTORE BLADD Based on the resident who enters indwelling catheter resident's clinical cocatheterization was who is incontinent o treatment and service.	iew and interview with IPN nurse) #3 on March 8, 1911, at nursing station, confirmed the ed the Amlodipine 5 may be order. HETER, PREVENT UTL. ER ent's comprehensive collity must ensure that a state facility without an is not catheterized unless the ordition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tenoticatore as much normal leadder	F 281	medication form) with new admissic admits. The education was done by DON, or ADON and was completed 24 th 2011. How the corrective action(s) will be monitored to ensure the deficient pwill not reoccur? The DON, ADON, and Unit Manage audit all new admits and re-admits to medication reconciliation has been defindings of the audits will be taken the Performance Improvement Committed ADON for the next 3 months beginn the meeting set for April 12 th 2011.	e practice ers will o ensure one. o the	
	by: Based on medical refacility policy and into complete a bladder a clinical justification for failed to offer treatments bladder function as part (#11) of twenty-four and the findings included Medical record reviewed admitted to the facility and interest and the facility and			F 315 483.25 (d) NO CATHETER, PREVENT UTI, RESTORE BLAD SS=D What corrective action(s) will be accomplished for those residents for have been affected by the deficient process of the series of the	und to practice? on form, atinence tified and added	4/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIED CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		IPLE CONSTRUCTION '	(X3) DATE SURVEY COMPLETED	
			445310	B. WI	√G		03/	09/2011
	PROVIDER OR SUPPLIER	PER BASI	N		1	REET ADDRESS, CITY, STATE, ZIP COD 66 COPPER BASIN INDUSTRIAL PA DUCKTOWN, TN 37326	Ę	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BE F	RECEDED BY F ".L	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION DATE
F 315	Continued From pa Medical record revienotes revealed the indwelling catheter. Review of the Minimals, 2011, revealed the Brief Interview for Mathematical the orientation, and record	ew of the resident v num Data e residen ental Sta ssible for	set dated February t scored "15" on the tus (BIMS) indicating	n g		Residents having an indwelling of current residents with indwelling were audited for completion of car justification sheet, bowel & bladd assessment, and incontinence que The monitoring was done by the ADON, Unit Managers and SDC completed by March 24 th 2011.	catheters atheter ler estionnaire.	
	Review of the facility Questionnaire" and the and Bladder Training tools had not been of Observation on Marc revealed resident #1 Foley catheter draining yellow urine was atta	's "Urinar the "Asse " reveale ompleted th 7, 2011 I lying su ige collec- ched to the	ssment for Howeld both assessment I, at 10:15 a m., pine in bed and a tion bag containing he bed rail. I resident #11 on			What measures will be put into systematic changes will be made that the deficient practice does not be catheter justification, bowel at assessment form and incontinence questionnaire form on any resident with a catheter or any current residently acquired catheter. The education by the SDC, DON, or ADON completed March 24th, 2011.	e to ensure not reoccur. n completing nd bladder t admitted dent with a sation was	11, 1, 1
t t r C li F ir	March 8, 2011, at 3:3 in bed and easily eng Continued interview reatheter "for quite so have to have it." Conthe facility had not offerstore bladder function of the facility Completing the Urinandwelling Catheter Aforms revealed4. If indwelling cather on a will complete the Indwelling ocumentation of a coumentation of a coumentation of a coumentation of a counter the line ocumentation of a counter the line of the line ocumentation of a counter the line of the line	aged in of evealed the time of the ered any on. The ered any on. The ered any on. The ered and eresid design of the resid design of the ered and elling Carrecord record r	onversation he resident had the and "wish I did not erview reverled freatment to d, "Guidelines for ments and ht and Other ent has an the charge rurse theter form."		A a b in A will b o b.	How the corrective action(s) will monitored to ensure the deficient will not reoccur? All current residents with catheter audited to ensure assessment of be bladder, catheter justification, and accontinence questionnaire were call residents being admitted with a will be audited by the DON, ADO dangers to ensure catheter justification timence assessment and bowed ladder assessment is completed. If the audits will be taken to the Pemprovement Committee by the Accept 3 months beginning with the recommittee of the second sec	s were wel and ompleted, catheters N, or Unit ation form, I and The findings erformance DON for the	

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/ JIA IDENTIFICATION NUM! :: 8:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION '	(X3) DATE SURVE COMPLETED	ΞY
670		445310	B. WING		03/09/20	11
	PROVIDER OR SUPPLIER ARE CENTER OF COPE	PER BASIN	1	TREET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK DUCKTOWN, TN 37326	PO BOX 518	
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES. MUST BE PRECEDED BY FU BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) MPLETION DATE
F 315	Catheter form,"		F 315	set for April 12 th , 2011.		
F 323	Wing on March 8, 20 of the UM, confirmed the bladder assessment indwelling catheter for restore bladder functional justification.	nit Manager (UM) of the No 011, at 3:25 p.m., in the of d the facility did not complete nent, questionnaire, or prm; did not offer treatment tion, and did not have for the indwelling catheler.	fice ete at to	E 222 492 25 (b) EDEE OF A COL	ALL)/nn11
SS=E	HAZARDS/SUPERV The facility must ens environment remains as is possible; and es adequate supervision	ISION/DEVICES ure that the resident s as free of accident hadan	ds	F 323 483.25 (h) FREE OF ACCID HAZARDS/SUPERVISION/DEVI SS=E What corrective action(s) will be	CES 4/12	2/2011
	prevent accidents.	16		accomplished for those residents fo have been affected by the deficient	practice?	;;
	by: Based on medical red documents, observati failed to ensure safety	is not met as evidenced cord review, review of lacility on and interview, the facility devices were in place to a residents (#14, #16, % #7 d residents.	tý	Resident #14, On March 8 th interventive resident were put into place and care a were updated to match current interventive ordered. Resident #16 On March 9 th interventive resident were put into place and care a were updated to match current interve orders. Resident #7 On March 8 th intervention resident were put into place and care a	plans intions ons for plans ntion ns for	
	13, 1999, with diagnos Disease, Hypertensior	nitted to the facility on July ses including Alzheimer's	2	were updated to match current interver Education with nurse to ensure docum that interventions were in place at time was begun and completed by March 24	ntions. entation of fall 4 th 2011.	
	history of falls. Reviev the facility, revealed th	v of documents provided be e resident experienced the njury on these dates. The	by e	Residents identified as having the po to be affected by the same deficient p What corrective actions will be taken	ractice,	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	INT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER SLIA IDENTIFICATION NUM : R:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE S COMPLE	
		445310	B. WING		03/0	9/2011
	PROVIDER OR SUPPLIER ARE CENTER OF COPI	PER BASIN		REET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK DUCKTOWN, TN 37326	PO BOX 518	3
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICIENCY)	ULD BE	(X5) COMPLETION DATE
	interventions put in as noted: June 4, 2 prevent sliding) to w to be placed against and August 2, 2010, applied to bed and of Medical record reviee provided by the facility sustained falls from and 16, 2010, with nown was in place and sour documentation the direcord review and reserve aled the resident injury from the bed of documentation the alsounding and no documentation the alsounding and no documentation the wall, with a fall materiew with the Uniterview wi	place following the falls were 010, Dycem (device to heelchair, July 16, 2010), bed the wall with mat at bodside, pressure alarms to be hair. w and review of documents the wheelchair on August 11, o documentation the alarm unding, and no yeem was in place. Medical view of facility documents, the sustained a fall without in October 27, 2010, with no farm was in place and umentation the mat was at the 8, 2010, at 8:20 a.m. Ilying in a low bed against at in place. It Coordinator in the Unit of March 8, 2010, at 10:30 esident's Care Plan had not est the interventions and the interventions		All residents at risk for falls have a be affected. All current residents we interventions in place for falls are be monitored every shift to ensure safe are in place and functioning properly hall nurse. Audits have been on going survey March 9th 2011. What measures will be put into place systematic changes will be made to that the deficient practice does not have safety devices are being utilized functioning properly every shift and documenting what safety devices we utilized and functionality at the time. The re-education was done by the SI or ADON and was completed by Ma 2011. How the corrective action(s) will be monitored to ensure the deficient period will not reoccur? In addition to the hall nurses monitorsafety devices every shift, the Unit M DON, SDC, and ADON are monitored devices once a week to ensure they are utilized and are functioning properly, findings of the audits will be taken to Performance Improvement Committed ADON for the next 3 months. The next appears of the set of the province of the set of the performance Improvement Committed ADON for the next 3 months. The next appears of the set of the performance of the	ho have cing try devices y by the ng since acc or o ensure t reoccur. Insuring and/or are being of a fall. DC, DON, reh 24th. The tractice are being and safety re being the the se by the	
- 1	dated December 17, 2	010, revealed the resident y problems, no long term				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/: I.I.A IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		445310	B. WING_	VI 20	03/(09/2011
	F PROVIDER OR SUPPLIER ARE CENTER OF COP	PER BASIN	_ 10	EEET ADDRESS, CITY, STATE, ZIP 66 COPPER BASIN INDUSTRIA UCKTOWN, TN 37326		Š
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FIRE SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	memory problems, cognitive skills; requirence and amburequired human asseted to standing,	and modified independence in uired limited assistance with lation; was not steady and sistance for moving from walking, turning around, and ransfers; had two falls, without	F 323			
* **	updated November	ew of the resident's care plan 18, 2010, revealed, "Place d & chair to alert staff of s"				
	December 20, 2010 "Found laying on barto bed. Bed alarm of Neuro check complethead. No redness notice pack applied to be Move all extremities review of the care plants."	ew of a nursing note dated, at 10:36 p.m., revealed, ok on floor next to walker next on. Confuse (confused) eted. Small bump on back of oted. Denies pain/headache, back of head for 15 min as before" Medical record an updated December 21, esident was placed on a lan,		E	*	
	December 26, 2010, "Found sitting bathro ofhead. Laceration Alert/confuse (confus to question. Bil (bilat equally/Brisk 2 mm (rheadache. Move all e Assisted back to bed alarm appliedreque (emergency room) for record review of the n	millimeter) size. Denies extremities as before. ambulate with walker. Bed sted to be sent to ER r Evaluation" Medical pursing notes revealed the in the emergency room on				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C. A IDENTIFICATION NUMB 18			(X3) DATE S	
		445310	B. WING _	· · · · · · · · · · · · · · · · · · ·	03/0	9/2011
322	PROVIDER OR SUPPLIER	PER BASIN	. 1	EET ADDRESS, CITY, STATE, ZIP CO 66 COPPER BASIN INDUSTRIAL P OUCKTOWN, TN 37326		8
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	orders to increase to dosages. Observation of the from 11:32 a.m., to the Director of Nurs room, confirmed the wheelchair with no to dosage.	resident on March 9, 2011, 11:35 a.m., and interview with ing (DON), in the resident's resident was sitting in a ab or personal alarm	F 323			
1	Observation of the r LPN (Licensed Prace 2011, at 11:36 a.m., resident's room, cor alarm in the wheelch pressure alarm in the revealed the LPN dialarm to the bed had Observation of the re 11:55 a.m., in the re	ON, after finding the alarm the the diarm to the resident. resident and interview with stical Nurse) #2 on March 9, and 11:50 a.m., outside the offirmed the resident had a table hair at all times and a le bed. Continued interview do not know when the prossure dibeen implemented. resident on March 9, 2011, at sident's room, revealed the long the side of the bed, and			es este	
	when lifted the botto sounded, and the resident had transhed and the resident already off." Continuoressure alarm on the resident moved his/had to sit down to quanterview with the Un p. 2011, at 11:47 a.m. confirmed the resident was to have	m, the pressure alarm sident quickly sat back down. sident, at that time, confirmed sferred, unassisted, to the stated the tab alarm, "was led interview confirmed the e bed alarmed whenever the er bottom and the resident let the alarm. It Coordinator (UC) on March in the UC's office, in the UC's office, atab alarm in the bed and is unaware the resident had				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES SLIA IDENTIFICATION NUM & R:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445310	B. WING_		03/0	9/2011
20	PROVIDER OR SUPPLIER RE CENTER OF COP	PER BASIN	·	REET ADDRESS, CITY, STATE, ZIP CO 166 COPPER BASIN INDUSTRIAL F DUCKTOWN, TN 37326		8
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMAT ON)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 16	F 323		29	
	resident's room, an interview with the Ep.m., at the nursing physician's order discontinued the pradded a tab alarm the care plan reflect interview confirmed alarm attached whill 11:32 a.m., and the to the wheelchair with the wheelchair with the whole and transferring una Continued interview risk for falls and the	r confirmed the resident was at resident had not been e of an alternative pressure				nancijin.
	23, 2010, and readn diagnoses including Alzheimer's Disease Fracture.	mitted to the facility on March nitted on June 4, 2010, with Muscle Weakness, e, and Right Humeral Head		*		
	dated January 24, 26 had short and long to totally dependent with assistance for bed mand bathing. Further ndicated pain by nor expressions and profurther review reveals be served one to two he review process. If	on the last five days in further review revealed the resident oblined by of a fall since admission.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED OF LIA IDENTIFICATION NUMBER:		(X2) MULTA. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		445310	B. WING		03/09/2011
	PROVIDER OR SUPPLIER RE CENTER OF COPI	PER BASIN	e .	REET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARI DUCKTOWN, TN 37326	(PO BOX 518
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I U.L. SC IDENTIFYING INFORMA: ON)	IĎ PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 323	Continued From pa	ge 17	F 323		
		ew of the Fall Risk July 3, 2010 through January the resident was at high risk		AS IN	8
54	dated August 2, 201 while in bed-check of	ew of a physician phone order 0, revealed "Pull tab alarm (every) shift for proper ementmat beside bed for			in the state of th
	Medical record revie dated August 10, 20 sides of bed"	w of a physician phone order 10, revealed "Mats to both			55 1
	August 12, 2010, rev 8/11/10. Res (Resid of bed) to bed side n	w of the nursing note lated realed "Late entry for lent) noted to climb OOB (out nat. Small abrasion area prearmno other injuries			C. C.
	October 17, 2010, re was witnessed to sta of bed and fall sidew head hitting head on Aide) was in room wiwitnessed and was u	w of the nursing note dated vealed "Res at 1:15pm nd up for (sic)sitting on side ays unto back and back of floor. cna (Certified Nurse th other resident and nable to get to res s in front of bed but not past			
. v	October 23, 2010, revivith head off (mat)i eyebrow. Neuros per ealled, MD notified an	v of the nursing note dated vealed "Res was on mat has reddened area left protocol. Res spouse d told res and spouse equest res is not going to			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENT	ERS FOR MEDICAR	E & MEDICAID SERVICES				OIVID NC	7. 0830-0381
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMB RE	1	IULTIP ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	12	445310	B. Wit	4G		03/0	09/2011
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F 323	Review of facility de 2010; October 17, January 10, 2011, fallen out of the bed documentation the Further review of the August 11, 2010, reintervention was to with a pull tab alarm documentation date the additional intervention mental check placement. Further documentation date the additional intervention wall, bed turplacing 3 mats vertified facility documentation date the facility document 2011, revealed the ensure the bedside against the wall. Review of the care prevealed Hi-lo bed, bed. Further review bed was not added an August 2, 2010, the alarm to bed was Observation on Marcrevealed the resident straps, in constant mon rail and got a skin revealed the resider	ocumentation dated August 11, 2010; October 23, 2010, and revealed the resident had and there was no bed alarm was sounding le facility documentation dated evealed the additional place the resident in a realiner n. Further review of the facility ad October 17, 2010, revealed	· F3	323			
		the wall with a mat between the bed was in a low					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION N	I-/CLIA MBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DAT	PLETED PLETED
	-	445310		B, WING		0:	3/09/2011
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 325 SS=D	position and a tab a linterview with the U Coordinator's office p.m., confirmed the safety devices were resident's falls. 483.25(i) MAINTAIL UNLESS UNAVOID Based on a resident assessment, the faresident - (1) Maintains acceptatus, such as bod unless the resident'demonstrates that the same status of the same status.	Just Coordinator in the on March 8, 2010, and the in place at the time N NUTRITION STATE DABLE It's comprehensive cility must ensure the stable parameters of y weight and protein	Unit 12:20 Hion the of the IS	F 325	F 325 483.25(i) MAINTAIN STATUS UNLESS UNAVO SS=D What corrective action(s) w accomplished for those residence been affected by the de Resident #2 received extra poliseuit and special request wa the dietary communication fo	ornil be dents found to efficient practice ortion of gravy as placed using	
	by: Based on medical re and interview, the fa choices in individual resident (#2) of twen The findings include Resident #2 was re- December 27, 2010, Sepsis, UTI (Urinary Dementia, and Parki	d: admitted to the facility with diagnoses inclu Tract Infection), Alzi	on ling imer's		Residents identified as having to be affected by the same down to be affected by the same down to be affected by the same down to be affected by the asked if they special requests from dictary to met. The special request audic by the dietary department and completed by March 24th 2011. What measures will be put in systematic changes will be much at the deficient practice down.	ng the potential eficient practice let taken? to be affected, y have any that are not being ts will be done will be l. nto place or nade to ensure per not reoccur.	

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIED LIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	-	(X3) DATE COMPI	
	as ar sec	445310	B. WING	ç			03/	09/2011
32 May 9	PROVIDER OR SUPPLIER ARE CENTER OF COPF	PER BASIN		166	T ADDRESS, CITY, STATE, ZIP COPPER BASIN INDUSTRIA CKTOWN, TN 37326		PO BOX 51	8
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FILL C IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOU HE APPRO	JLD BE	(X5) COMPLETION DATE
F 325	long and short term moderately impaired	memory problems, I cognition, was totally or all activities of daily I ving	F 325	d tl	itchen anytime a resident is ietary request. The re-educine SDC, DON, or ADON as farch 24th 2011.	ation wa	s done by	
. 22 22	March 8, 2011, at 8:3 room revealed the re a biscuit and gravy, v	erview with the resident on 30 a.m., in the resident's sident stated breakfast was which the resident atc "all" ted more biscuit and gravy, as no more.		m W D cc er	ow the corrective action (sonitored to ensure the deall not reoccur? Sietary staff member will mean the monthly for the next is use that all dietary special	ficient peet with 3 month l request	resident as to	
	who fed the resident) 8:35 a.m., at the nurs	Certified Nursing Assistant #1 on March 8, 2011, at sing station, confirmed the eal was biscuits and gravy dia second serving.		m In M	eing followed up on. The fi ectings will be taken to the approvement Committee by anager for the next three m ith the next meeting set for	Perforn the Diet onths be	nance ary eginning	
	Dietary Manager on N in the Dietary Manage had not requested a s gravy for the resident, received a second set department was unaw	rving, and the dietary	d		2			
	March 8, 2011, at 9:05 room, confirmed the re another serving of bisc			3.5				
	Interview with CNA #2 a.m., at the nursing sta resident had eaten app second serving of bisc interview revealed, "(re	proximately half of the uit and gravy. Further				3		

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	ENT OF DEFICIENCIES N OF CORRECTION .	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MUL A. BUILD	TIPLE CONSTRUCTION '	(X3) DATE : COMPL	SURVEY LETED
		445310		B, WING		03/0	09/2011
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F 32	biscuit and gravy so and say we didn't g Interview with the D Assistant Dietary M 8:40 a.m., and on M the Dietary Manage	the resident can get in	11, at .: m., in	F 328			
F 364 \$\$=F	servings of food wheresidents. Further in resident was consided dietary department in resident's special diresident received opneeds. Further intercommunicated the redietary department apreferences had not 483.35(d)(1)-(2) NU	en staff requested it for nterview confirmed the ered a nutritional risk an needed to be informed etary requests to ensur- bitinum nutrition to mec- rview confirmed staff has esident's requests to the and the resident's dietar been honored. TRITIVE VALUE/APPI	nd the of the e the did not	F 364	F 364 483.35(d)(1)-(2) NUTRIVI VALUE/APPEAR, PALITABLE TEMP	E E / PREFER	4/12/2011
25	food prepared by me value, flavor, and ap palatable, attractive, temperature.	res and the facility proviethods that conserve nepearance; and food the and at the proper	dritive		SS=F What corrective action(s) will be accomplished for those residents have been affected by the deficient	s found to	
· ·	by: Based on observation failed to serve food a The findings included Observation of the re	n and interview, the fact t a palatable temperate l: sidents mid-day meal arch 9, 2011, at 11:13	iiity ire.		On March 9th starting with the ever trays, residents not in dining room delivered to rooms immediately ar sitting in the dining room for any patime. Process has been ongoing sitting. Residents identified as having the	trays were ad not left period of nee that	

Facility ID: TN7001

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIES (X1) PROVI

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE CLIA IDENTIFICATION NUTBER:	(X2) MÜL A. BUILD	TIPLÉ CONSTRUCTION ING	COMPL	
34	1/4	445310	B. WING		03/0	9/2011
	PROVIDER OR SUPPLIER ARE CENTER OF COPF	PER BASIN		TREET ADDRESS, CITY, STATE, ZIP O 166 COPPER BASIN INDUSTRIAL DUCKTOWN, TN 37326		3
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY LULL SCIDENTIFYING INFORMA(100N)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 364	1.) Meatloaf and tur Fahrenheit (F). 2.) Mashed potatoe 3.) Pureed meatloa were 168 degrees F 4.) Milk was 34 deg	mip greens were 164 legrees s was 170 degrees F f and pureed turnip greens rees F.	F 364	to be affected by the same d What corrective actions wil All residents have a potential and the facility will ensure th delivered at the proper tempe What measures will be put i	to be affected, c meals are ratures.	
*	of being filled. Obse contained fifteen tray and was completed a department at 11:21 the floor at 11:22 a.n revealed the first tray at 11:22 a.m.; last tray	ested for the cart in process prvation revealed the cart /s with the test tray included at 11:20 a.m.; the cart left the a.m., and was delive ed to n. Further observation was removed and delivered by delivered was 12:01 p.m., served began eating at		systematic changes will be near that the deficient practice deficient practice defined available staff will assist a delivered to the residents. All re-evaluated for appropriate defines efforts will ensure that reoccur.	nade to ensure oes not reoccur. with the meals residents will be ining locations.	4.
	test tray remained on the floor at 11:22 a.m tray cart, containing fi usually ate in the dining was delivered to the f a.m. Observation revidelivered the five tray to the floor at 11:53 a	done resident tray and the the tray cart that arrived to the trays for residents who are room but decided not to door at approximately 11:53 realed the nursing staff is from the cart that a dived and on the cart that arrived at		How the corrective action(s) monitored to ensure the defi will not reoccur? The CDM and or the Assistant 10% of trays weekly to ensure meals are at the proper temper they receive them. These findibrought to the Performance Im Committee monthly for six mocompliance. The next meeting 12th 2011.	t CDM will audit the resident's atures when ngs will be uprovement onths to ensure	
2 3 4 V	12:07 p.m. with the fol 1.) Meatloaf was 106 2.) Turnip greens was 3.) Mashed potatoes	ager from the test tray at llowing results: degrees F. s 110 degrees F. was 112 degrees F. and pureed turnip greens				

PRINTED: 03/14/2011 DEPARTMENT OF HEALTH AND HUMAN SER J'CES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLII :: CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NL ... IER; AND PLAN OF CORRECTION A. BUILDING B WING 445310 03/09/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER . 166 COPPER BASIN INDUSTRIAL PARK PO BOX 518 LIFE CARE CENTER OF COPPER BASIN DUCKTOWN, TN 37326 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY I'LL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORM/ FON) TAG TAG DEFICIENCY) F 364 F 364 Continued From page 23 Interview, with the Assistant Dietary Manager on March 9, 2011, at 12:09 p.m., outside the 100 hall Day Room confirmed the test tray food temperatures had decreased significantly from the tray line temperatures. Further interview revealed the food "was not hot enough and the milk (temperature) was to high." Interview of five of five residents in the group n rant meeting, on March 8, 2011, at 2:30 p.m., revealed the "food was barely warm." 4/12/2011 F 371 483.35 (i) FOOD PROCURE, F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY STORE/PREPARE/SERVE - SANITARY SS=F The facility must -(1) Procure food from sources approved :: considered satisfactory by Federal, State or local What corrective action(s) will be authorities: and accomplished for those residents found to (2) Store, prepare, distribute and serve food have been affected by the deficient practice? under sanitary conditions The individual storage bins and floor mixer were immediately cleaned. The clean rack of dishes that were placed on the floor were rewashed and placed off floor. The clean dish

This REQUIREMENT is not met as evidenced

Based on observation and interview, the facility failed to maintain sanitary equipment in the dietary department.

The findings included:

Observation on March 7, 2011, at 11:56 a m., with the Director of the Dietary Department revealed the following:

 Four individual storage bins containing cornmeal, flour and sugar had dried red and black racks that were ejected by the dirty dish rack were re-washed.

Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?

All resident have a potential to be affected. The individual storage bins and floor mixer were immediately cleaned. The clean rack of dishes that were placed on the floor were rewashed and placed off floor. The clean dish

1744 - 774 ...

03/24/2011 19:43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF LIA IDENTIFICATION NUM / R:	A. BUILE	DING	COMPLETED
		445310	B. WING	W. St. Schmidterstein, Address and St. St.	03/09/2011
100	PROVIDER OR SUPPLIER RE CENTER OF COPF	PER BASIN	3	TREET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK DUCKTOWN, TN 37326	PO BOX 518
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FILE BC IDENTIFYING INFORMAT (N)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	ULD BE COMPLETION
	the bins. 2. The floor mixer up the back of the base had an accumulation splatfered debris. Observation of the doon March 8, 2011, at of the Dietary Depart Manager revealed the 1.) Two dish racks a floor. 2.) The dietary staff side of the dish mach dirty dishes into the robservation revealed contact with the rack machine. Continued clean rack of dishes machine by the dirty dishes into the robservation revealed contact with the Directon of the lids and exterior confirmed the four stoon the lids and exterior confirmed the floor mixed white and tan or the underside of the base and the exterior revealed the floor mixed white and tan or the lids and exterior revealed the floor mixed white and the confirmed the floor mixed and the exterior revealed the floor mixed and the exteri	e lids and exterior subject of inderside of the beater arm, and the exterior of the base in of white and tan colored lishroom operation in process to 1:50 p.m., with the Director tment and Assistant Diotary in following: In the direction of the direction of clean dishes inside the observation revealed the was ejected from the rack of dishes. In the direction of dishes inside the observation revealed the was ejected from the rack of dishes. In the direction of dishes inside the observation revealed the was ejected from the rack of dishes. In the direction of dishes inside the observation revealed the was ejected from the rack of dishes. In the direction of dishes inside the observation of clean dishes inside the observation of dishes. In the direction of the disher interview in the direction of the Dietary was eater arm, the back of the surface. Further interview were had not been used on the disher interview were had not been used on the disher interview were had not been used on the disher interview was sistant Dietary Manager 1:50 p.m., confirmed two	F 37	racks that were ejected by the dirty of were re-washed. What measures will be put into ple systematic changes will be made to that the deficient practice does not Kitchen staff were re-educated on er that storage bins and mixer are clean process to ensure clean dishes do no dirty surfaces after they have been with the re-education was done by the Dimanager and was completed by Mar 2011. How the corrective action(s) will be monitored to ensure the deficient pwill not reoccur? What Quality Arrogram will be put into place? The cook is auditing daily to ensure storage bins are clean and floor mixed clean and that clean dishes are not to dirty surfaces. The findings of the and be taken to the Performance Improve Committee by the Dietary Manager in next three months beginning with the set for April 12 th 2011.	ace or o ensure t reoccur. asuring and and the t touch vashed. ietary ach 24th e practice ssurance food ar is kept uched by udits will ement for the

PRINTED: 03/14/2011 FORM APPROVED

		AND HUMAN SERVICES			FORM APPROVED B NO. 0938-0391
STATEMEN	RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE - DLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		DATE SURVEY COMPLETED
		445310	B. WING	*	03/09/2011
	PROVIDER OR SUPPLIER RECENTER OF COPI	PER BASIN	*	REET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK PO B DUCKTOWN, TN 37326	OX 518
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY 11 LL SC IDENTIFYING INFORMA (1)N)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION DATE
F 371 F 441 \$\$=E	the machine in orde	er to eject the clean rock of	F 371	F 441 483.65 INFECTION CONTROL PREVENT SPREAD, LINENS	4/12/2011
	Infection Control Prosafe, sanitary and control to help prevent the confidence of disease and infection Control The facility must est Program under which (1) Investigates, continuous the facility; (2) Decides what proshould be applied to (3) Maintains a reconactions related to infection (b) Preventing Spread (1) When the Infection determines that a reprevent the spread contact when the infection displayed in the facility must communicable disease from direct contact will train (3) The facility must	Program tablish an Infection Centrol ch it - ntrols, and prevents in fections becauses, such as isolation, an individual resident; and rd of incidents and corrective fections. ad of Infection on Centrol Program sident needs isolation to of infection, the facility must prohibit employees well a use or infected skin lesions with residents or their food, if insmit the disease. require staff to wash their ect resident contact for which cated by accepted		What corrective action(s) will be accomplished for those residents found have been affected by the deficient practices with tracheostic care was done with all licensed nurses gived direct care to resident was begun on March 2011 and completed on March 24 th 2011. education for all nursing staff on infection control practices with tracheotomy care we begun on March 8 th 2011 and completed of March 24 th 2011. Resident #2 One on one re-education on infection control practices during dressing change was done with the wound care nur March 8 th 2011. Licensed nursing staff reeducation on infection control practices direction on infection control practices during staff reeducation on infection control practices direction on in	omy ving ch 8th Rc- n vas on uring 2011
		die, store, process and sto prevent the spread of		All residents have a potential to be affected. The infection control nurse and DON reviall residents with active infections to ensure residents were receiving appropriate isola precautions. The review was completed by	iewed ire tion

PRINTED: 03/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF & LIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUM 1:R: A. BUILDING B. WING 445310 03/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK PO BOX 518 LIFE CARE CENTER OF COPPER BASIN DUCKTOWN, TN 37326 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMAT ... N) TAG TAG DEFICIENCY) March 9th 2011. F 441 Continued From page 26 What measures will be put into place or systematic changes will be made to ensure This REQUIREMENT is not met as evidenced that the deficient practice does not reoccur. Based on medical record review, observation, Nursing staff was re-educated on appropriate policy review, and interview, the facility failed to isolation. Licensed Nurses were re-educated change gloves properly during trachestony care on infection control techniques for for one (#3); failed to wash/cleanse the hands tracheostomy care and wound care. The properly during care of a pressure ulcer for one cducation was done by the infection control (#2), and failed to isolate two residents with nurse, SDC, DON, or ADON and was multiple drug resistant organisms (#1, #11) of completed by March 24th 2011. twenty-four residents reviewed. How the corrective action(s) will be The findings included: monitored to ensure the deficient practice will not reoccur? Resident #3 was admitted to the facility on Infection control technique audits for wound October 5, 2004, with diagnosis including care and tracheostomy care are being done Bronchitis and Brain Injury post Motor Vehicle three times a week by the infection control Accident. Medical record review revealed nurse. Isolation precautions audits are being resident #3 was completely dependent on the ... done 3 times a week by the infection control staff to meet all needs. nurse to ensure residents are in appropriate isolation. Findings of the audits will be taken Observation on March 7, 2011, at 10:50 a.m., to the Performance Improvement Committee revealed resident had a Tracheostomy (a by the ADON for the next three months surgically created opening creating a direct sirway beginning with the next meeting set for April to the trachea/windpipe) and was receiving 12th 2011. supplemental oxygen via trach collar. Continued observation revealed Licensed Practical Nurse

(LPN #1) was in the process of performing tracheostomy. Continued observation revealed LPN #1 (with gloved hands) used a gauze uponge and removed yellow secretions from around the stoma (the opening) then disposed of the gauze in the garbage. Continued observation revealed LPN #1 without removing the gloves, picked up the saline bottle and put it in the bedside drawer

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ UA IDENTIFICATION NUME RE	(X2) MULTI A. BUILDING	PLE CONSTRUCTION	(X3) DATE S	
		445310	B. WING _		03/0	9/2011
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F 441	and closed the dra Continued observation reveals and prepared to change the airway op replaced periodical cannula containing on a paper towel are gloves, placed the outer cannula of the Interview with LPN March 7, 2011, at 1 contaminated glove handling the normal handle and verified not removed prior to cannula.	wer with the gloved hands, tion revealed LPN #1 removed ansed the hands. Continued and LPN #1 gathered equipment ange the inner cannula trach annula remains in place to en and the inner cannula is ly). LPN #1 removed the inner yellow secretions and placed it not without removing the new inner cannula into tire a Trachestomy. #1 in the resident's room on 1:08 a.m., verified the is were not removed prior to I saline bottle and drawer the contaminated gloves were or inserting a new inner	F 441			
	confirmed the facility prevention protocol Resident #11 was as January 27, 2011, w Rehabilitation and U Medical record revie admitted with an ord one tablet for 5 days for a UTI (Urinary Tr. Medical record review	March 8, 2011, at 1:18 p m., y failed to follow infection to separate dirty from clean. Idmitted to the facility on ith diagnoses including rinary Tract Infection. We revealed resident #1: was er for Septra DS (antibiotic) to complete the treatment act Infection). We of the admission nursing esident was admitted with an		II		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ HA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		445310	B. WING		<u> </u>	03/	09/2011
	PROVIDER OR SUPPLIER ARE CENTER OF COPP	PER BASIN	166	6 C	ADDRESS, CITY, STATE, ZIP CODE COPPER BASIN INDUSTRIAL PAR KTOWN, TN 37326		18
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY Ft 11 SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	, , ,	ge 28	F 441		a .		
	revealed resident #1	11 lying supine in bed and a age collection bag consining		2	40		
		ew of the admission orders 011, revealed an order for a UA) with Culture and			es.		
		w revealed a telephone order 011, to obtain a Urinalysis asitivity.			8		
	Medical record review UA and C/S for February	w revealed no results of the uary.			*		*
	culture and sensitivity revealed the resident (UTI) with greater that	w of the urinalysis with probability obtained March 6, 20 l 1, thad a urinary tract infection on 100,000 Escherichia colistant to all antibiotics except			· .		****
i i c	revealed "Contact Pre this facility to use con- residents known or su linesses easily transn contact or by contact v environment Exampl	ses revised May 21, 2004, ecautionsIt is the intent of tact precautions for ispected to have serious nitted by direct resident with items in the residents' es of Infections When			¥		
1	Contact Precautions N Multi-resistant organis Resistant Enterococcu	ms (e.g. VRE [Vancomycin				æ	
	nterview with the Infed March 9, 2011, at 10:4	otion Control Practitioner on 0 a.m., in the Unit				*	

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE:// IDENTIFICATION NUI::5	OLIA	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	
		445310		B. WING		03/0	9/2011
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F 441	Social Services offi multi-drug resistant placed in contact is confirmed the resid E. Coli UTI infection	age 29 a, and at 11:30 a.m., inces, confirmed resident E. Coli UTIs were to be olation. Further intervient had a multi-drug rand had not been plut indicated by the facility	s with w sistant ed in	F 44			a esta last.
	March 4, 2011, with Tract Infection, Den Medical record revied dated February 26, had long and short to severely impaired co	-admitted to the facility diagnoses including the nentia, and Alzheimer; and of the Minimum Data 2011, revealed the resident memory problems ognition, totally dependent of daily living and was er.	rinary n Set dent ent on				
	and sensitivity obtain revealed the residen (UTI) with greater the	ew of a urinalysis and of ned February 28, 2011, it had a urinary tract info an 100,000 Escherichis sistant to all antibiotics	ection coli			3 ·	1,4
t r i c	Communicable Diservealed "Contact Problem is facility to use concession or significant contact or by contact environment Example ontact Precautions	's policy Isolation for ases revised May 21, 21 recautionsIt is the intentact precautions for uspected to have serior mitted by direct resident with items in the resident with item	ent of us t ents'				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/COA IDENTIFICATION NUMB 15	(X2) MUL	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445310	B. WING		03/09/2011	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COPPER BASIN			s	TREET ADDRESS, CITY, STATE, ZIP COD 166 COPPER BASIN INDUSTRIAL PA DUCKTOWN, TN 37326	E RK PO BOX 518	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FU!! SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE COMPLET	TION
	through 4:00 p.m., ralways lying in bed, roommate who was and there was no si was in contact isola. Interview with the In March 9, 2011, at 10 Coordinator's office, multi-drug resistant in contact isolation. the resident had a minfection and had no isolation as indicated. Resident #2 was addicated to be comber 27, 2010, Sepsis, UTI (Urinary Dementia, and Parki Medical record revier Status Record dated resident had a stage	n 7-9, 2011, from 9:00 mm., revealed the resident was dependent on staff, with a independent in a wheelchair, gn to indicate the resident tion. fection Control Practitioner on 0:40 a.m., in the Unit, confirmed residents with E. coll UTIs were to be placed Further interview confirmed nulti-drug resistant E. coll UTI of been placed in contact d by the facility's policy. mitted to the facility on with diagnoses including Tract Infection), Alzheimer's inson's Disease. w of the Pressure Ulcer III pressure ulcer on the left of confirmed on the	F 44			
	Observation of a dre- ulcer on March 7, 20 resident's room, with nurse) #4, revealed t removed the old dres biohazard bag; withors sanitizing the hands, syringe full of normal	ssing change to the pressure 11, at 3:10 p.m., in the LPN (licensed practical he LPN, with gloved hands, ssing and placed it in a ut changing gloves or irrigated the wound with a saline; removed the gloves, of the hands, donned clean	c			
		l l				- 1

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		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES (LIA IDENTIFICATION NUMBER R:	(X2) MUL* A. BUILDI	NG	COMPLE	
		* .	445310	B. WING		03/09	9/2011
		PROVIDER OR SUPPLIER ARE CENTER OF COP	PER BASIN		REET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK DUCKTOWN, TN 37326		
1	(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FILL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
*	F 441	Review of the facili Pressure Sores, Cl revealed, "5. Ren no-touch technique Remove gloves and use antiseptic hand gloves 8. Cleanse Remove gloves and bag10. Wash ha	ty's policy Treatment of hapter 3 (3-41 no date), move soiled dressing using and place in bag for disposal, discard6. Wash hands or cleanser7. Apply new wound as directed9 discard in disposable ands or use antiseptic hand	F 441			
89 8		wound care as orde	y new gloves and perform ered" #4 on March 7, 2011, : 1:3:25		* ** * * * * * * * * * * * * * * * * * *		
	F 502 SS=D	p.m., outside the re- LPN did not change hands according to 483.75(j)(1) PROVII SVC-QUALITY/TIM The facility must pro- services to meet the	sident's room, confirmed the gloves and sanitize the the facility's policy. DE/OBTAIN LABORATORY	F 502	F 502 483.75(j)(1) PROVIDE/OBT LABORATORY SVC- QUALITY/TIMELY SS= D	TAIN	4/12/2011
S		This REQUIREMEN by: Based on medical re and interview, the fa	T is not met as eviderced ecord review, observation, cility failed to obtain a re and Sensitivity for conservations reviewed.	200.0	What corrective action(s) will be accomplished for those residents f have been affected by the deficient Resident # 11 A urinalysis was obtained to march 9th 2011 and resulting.	t practice?	50
		dated January 27, 20	w of the admission orders 111, revealed an order to the month. Medical record		Residents identified as having the to be affected by the same deficien What corrective actions will be tal All residents have a potential to be a Residents with orders for a U/A since	it practice. ken? iffected.	eryog zoslok

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION '	(X3) DATE S	SURVEY ETED
	3 8.0	445310	B. WING.		03/0	9/2011
	PROVIDER OR SUPPLIER ARE CENTER OF COPF	PER BASIN		REET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK DUCKTOWN, TN 37326	< PO BOX 518	3
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE
F 502	revealed an order do obtain a UA & C/S (I Sensitivity). Review of the medic for the UA and C/S. Observation on Marc revealed resident #1 Foley catheter drains yellow urine attached. Telephone interview a.m., with the hospital performs the laborate	ated February 6, 20 11, to Urinalysis with Culture and all record revealed represults th 7, 2011, at 10:15 a.m., 1 lying supine in bed and a age collection bag containing	F 502	have been obtained and followed u- audits were conducted by the Unit DON, ADON and SDC and were o by March 24th 2011. What measures will be put into p systematic changes will be made that the deficient practice does not Licensed Nursing staff were re-edu process for obtaining U/A's when o ensuring they are followed up on. I education was done by the DON, A SDC and was completed March 24th	Managers, completed blace or to ensure of reoccur. ucated on ordered and The ADON, or the 2011	
F 514 SS=D	March 9, 2011, at 9:1 failed to obtain the Un Sensitivity as ordered 483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practice.	TE/ACCURATE/AC ESSIB	F 514	How the corrective action(s) will monitored to ensure the deficient will not reoccur? DON, ADON, or Unit Managers an orders daily to ensure that any U/A been obtained and followed-up on findings of the audits will be taken Performance Improvement Commit ADON for the next three months be with the next meeting set for April	e reviewing order has The to the ttee by the eginning	rum gendeli
	systematically organize The clinical record musinformation to identify resident's assessmen services provided; the	ed. sst contain sufficient the resident; a record of the ts; the plan of care and	1	F 514 483.75 (I) (1) RES RECORD COMPLETE/ACCURATE/ACCE SS= D What corrective action(s) will be accomplished for those residents followed been affected by the deficient	essible	4/12/2011

03/09/2011

(X5) COMPLETION

DATE

445310

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PRINTED: 03/14/2011 FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED

B. WING

NAME OF PROVIDER OR SUPPLIER

(X4) ID PREFIX

TAG

LIFE CARE CENTER OF COPPER BASIN

STREET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK PO BOX 518 DUCKTOWN, TN 37326

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

F 514 Continued From page 33

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of the Pain Flow Sheet, review of the medication and controlled drug policies, observation, and interview, the facility failed to maintain accurate medical records for two residents (#7, #8) of twenty-four residents reviewed.

SUMMARY STATEMENT OF DEFICIENCIES

REGULATORY OR LSC IDENTIFYING INFORMATION)

(EACH DEFICIENCY MUST BE PRECEDED BY FI

The findings included:

Resident #7 was admitted to the facility on March 23, 2010, and readmitted on June 4, 2010, with diagnoses including Muscle Weakness, Alzheimer's Disease and Right Humeral Hand Fracture.

Medical record review of the Minimum Data Set dated January 24, 2011, revealed the resident had short and long term memory problems totally dependent with two plus person physical assistance for bed mobility, transfer, toilet use and bathing. Further review revealed the resident indicated pain by non-verbal sounds, facial expressions and protective body movements. Further review revealed pain or possible pain was observed one to two days of the last five days in the review process.

Medical record review of the physician phore order dated August 4, 2010, revealed "...Duragesic patch (pain medication) every 3 days for pain..."

Medical record review of the September 2010, Recapitulation Orders, to the present revealed "...Fentanyl 25mcg/hr (micrograms per hour) patch (Duragesic) TD72 (Transdermal) apply and F 514

ID

PREFIX

TAG

Resident #7 On March 9th 2011 nursing giving direct care to resident received one on one reducation to ensure two nurses document narcotic patch destruction.

Resident #8 On March 9th 2011 Licensed Nurse giving care to resident received one on one re-education to ensure that narcotics given are signed out on front of MAR, back of MAR

Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?

and on controlled substance sheet.

All residents receiving a controlled substance have a potential to be affected. Residents currently having a narcotic medication patch MAR/controlled substance record were audited to ensure policy for narcotic patch destruction was being followed. Resident currently on a controlled substances MAR/controlled substance records were monitored to ensure number of times given matches.

What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not reoccur.

Licensed Nurses were re-educated on Policy for control substance documentation and destruction of controlled substances patches. The education was given by the SDC, DON, or ADON. The education was completed on March 24th 2011.

How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur? 03/24/2011 19:43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE //CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION '	(X3) DATE S COMPLI	
	36 3	445310	B. WING_		03/0	9/2011
	PROVIDER OR SUPPLIER RECENTER OF COP		1	REET ADDRESS, CITY, STATE, ZIP COL 66 COPPER BASIN INDUSTRIAL PA DUCKTOWN, TN 37326		3
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY 1000L LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION COROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	· (X5) COMPLETION DATE
FSVF	review revealed the Duragesic patch, of document" Review of the Med for the removal of the document revealed August 2010: there nurses on August 8 September 2010: de the patch daily exceindicated by one or October 2010: the signatures. November 2010: the signatures. November 2010: the signatures. November 2010: the two nurses on December 2010: the two nurses on December 2010: the two nurses on December 2011: there two nurses on January 2011: there two nurses on February 2011: the diagnoses in the diagnoses includes the medical reconcept the the medical reconcept the two diagnoses includes the two diagnoses includes the patch in the diagnoses includes the two diagnoses includes	ery 72 hours" Continued a order for "Upon removal of estroy it. Two nurses to feation Administration Records the patch with two nurses to the following: was no documentation by two signatures. entire month had no ere was no documentation by ember 18 and 27. ere was no documentation by ember 12 and 30. was no documentation by early 10, 13, 19, 22, 25, 38, re was no documentation by early 3, 6, 12, 21, and 27. irector of Nursing on March the two nurses document the two nu	F 514	Unit Managers, DON, ADON, a monitor control substance recort to ensure that the number of time matches on the MAR front and the Narcotic Control Substance narcotics are wasted per facility Findings of audits will be taken Performance Improvement Company ADON for the next 3 months be the next meeting set for April 12	ds once a week es given back and on sheet, and policy. to the mittee by the eginning with	

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER :IA IDENTIFICATION NUM : R:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	
	5 8	445310	B. WING		03/0	9/2011
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COPPER BASIN		160	ET ADDRESS, CITY, STATE, ZIP C 6 COPPER BASIN INDUSTRIAL ICKTOWN, TN 37326	CODE PARK PO BOX 518		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FILL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	Lumbar/Lumbarsac Obesity. Medical record revidated November 30 was 15 out of 15 for the highest level; record person physical transfer, ambulation bathing. Continued had received sched pain medication and pain. Continued revexperienced pain "fintensity, with zero knows pain imagined worst pain imagined " Endocet (pain medical record review order dated Februar " Endocet (pain medical record review for the Medical record review for the Endoced the Endoc	ew of the Minimum Data Set 0, 2010, revealed the resident r cognitive skills, with 15 being quired limited assistance with I assistance for bed mobility, n, dressing, toilet use, and review revealed the resident uled and as needed (PRN) d non-medical intervention for iew revealed the resident requently" with a 5 out of 10 peing no pain and ten the ew of the physician phone by 21, 2011, revealed edication) 10/325 mg h PRN (by mouth every 4 ain)" w of the March 2011, ration Record (MAR) et (Percocet) 10/325 mg po Q stered as follows: March 2 n; March 4, two times; March ch 7, three times. The back	F 514			
	Controlled SubstanceOxycod-Acetamin	w of the March 2011, e Record for (Endocet/Percocet) 10/325 urs as needed for pain	738			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER FILIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION LDING	(X3) DATE S	
		445310	B. WIN	G	03/0	9/2011
	PROVIDER OR SUPPLIER RECENTER OF COP	PER BASIN		STREET ADDRESS, CITY, STATE, ZIP CC 166 COPPER BASIN INDUSTRIAL F DUCKTOWN, TN 37326		3
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 514	revealed removal or as follows: March 2 times; March 4, thre and March 7, four ti	ge 36 f the medication from supply four times; March 3, two te times; March 5, one time; mes. Further review revealed to be dispensed as of March 9,	F 5	14		
	revealed Endocet/Po as follows: March 2 and 3, no d time; March 5, no do	ocumentation; March 6, one 7, no documentation.				vener e
	each medication in t after the medication medication is charte- given in the corner o	led "Procedure13, Initial he correct box on the MAR	12.			
	each dose of the con documenting: a. Date named. Physician	re 4. The nurse signs off trolled drugs given by eb. Hourc. Resident eb. Amount dispensed of g. Balance after subtracting				
] 1		h 9, 2011, at 8:45 a.m. of eket revealed ten pills		e		
(confirmed the MAR a did not coincide with t	ed Practical Nurse #5 dministration documentation he back of the MAR for the administration			¥	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/SI IA IDENTIFICATION NUMBER:		(X2) MU A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATES	BURVEY	
		445310	B. WING	G	03/0	9/2011
	PROVIDER OR SUPPLIER RECENTER OF COP	PER BASIN		STREET ADDRESS, CITY, STATE, ZIP 166 COPPER BASIN INDUSTRIA DUCKTOWN, TN 37326	CODE L PARK PO BOX 51	8
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FIRE SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 514	match the Controlle	onfirmed the MAR did not ad Substance Record on the ad confirmed the medical	, F 5°	14		
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		g 19	S 8. 8			La Mic
		Si Si	<u>.</u>			. i.
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